PLEASE HAVE YOUR DOCTOR COMPLETE AND SIGN THIS FORM.
POR FAVOR ENTREGUE ESTA FORMA A LA OFICINA DE SU DOCTOR PARA QUE LA LLENE Y LA REVISEN. ENTREGUE ESTA FORMA CON SU APLICACIÓN LO MAS PRONTO POSIBLE. GRACIAS.

SUN METRO LIFT
5081 Fred Wilson
El Paso, Texas 79906

Dear Doctor,

The attached authorization form has been submitted by your patient, who has indicated that you can provide information regarding their disability and its impact upon their ability to utilize our wheelchair-lift-equipped regular city buses. Federal law requires that Sun Metro provide paratransit services only to persons who cannot utilize available accessible regular city buses. The information you provide will allow us to make an appropriate evaluation of this request and its application for specific trip requests. Thank you for your cooperation concerning this matter.

Capacity in which you know the applicant: _____

Medical Diagnosis of condition causing the disability:

ls the condition temporary? No ___ Yes ___

Expected duration until _____

If the person has a disability affecting mobility, is the person:
Able to travel ¼ mile without assistance? No ___ Yes ___

Sometimes _____

Able to wait outside for 10 minutes? No ___ Yes ___

Sometimes _____

Does the person use any mobility aids? If so, what? _____

If the person has a visual impairment, visual acuity with best correction:

Right eye _____ Left eye _____ Both eyes _____

Visual Fields:

Right eye _____ Left eye _____ Both eyes _____

If the person has a cognitive disability, is the person able to:

Give addresses and telephone numbers upon request?
No ___ Yes ___

Deal with unexpected situations or unexpected changes in routine?
No ___ Yes ___

Ask for, understand and follow directions?
No ___ Yes ___

Safely and effectively travel through crowded and/or complex facilities?
No ___ Yes ___

Be trained to transfer from one route to another on the regular city bus?
No ___ Yes ___

Is there any other condition of the disability of which Sun Metro should be aware?

Please describe disability and define effects in non-medical terminology:

Your Name: _____

Office Address: _____

Office Phone Number: _____

Signature: _____ Date: _____

Reset All